NORTHERN DUTCHESS HOSPITAL

HEALTHQUEST

Outpatient Physical Medicine
6511 Springbrook Ave.
Rhinebeck, NY
12572

Phone (845) 871-3427
Fax (845) 871-4307

Name:	**DOB:**	**Age:**
Referring Physician:	Next Physician Visit:	
Are you working? ☐ YES (Full time/Part time) ☐ NO Occupation:	Does your job require: 1. Prolonged sitting ☐ YES ☐ NO 2. Physical labor ☐ YES ☐ NO 3. Chemical Exposure ☐ YES ☐ NO	
Living Situation: ☐ Live alone ☐ Live with: ☐ Assistance from Home Health Aide	Living Environment: ☐ Home (single level/multi-level) ☐ Apartment (Stairs/Elevator) ☐ Assisted Living Facility	

Have you ever been diagnosed as having any of the following conditions? (Check all that apply)

Heart
- ☐ Pacemaker/Defibrillator
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Arrhythmia
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Palpitations
- ☐ Congestive Heart Failure
- ☐ Other:

Blood/Circulation
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Bruise easily
- ☐ Hepatitis (Type:)
- ☐ Deep Vein Thrombosis
- ☐ Calf pain when walking
- ☐ Cold hands/feet
- ☐ Varicose Veins
- ☐ Raynaud's
- ☐ Lymphedema
- ☐ Other

Gastrointestinal
- ☐ Stomach Ulcer
- ☐ Irritable Bowel Syndrome
- ☐ GERD (reflux)
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Celiac Disease/Gluten Sensitivity (circle one)
- ☐ Gall Stones
- ☐ Gas/Bloating
- ☐ Constipation
- ☐ Other:

Kidney
- ☐ Kidney Failure
- ☐ Pain with urination
- ☐ Urinary Incontinence
- ☐ Blood in urine
- ☐ Recurrent UTI
- ☐ Kidney Stones

Endocrine
- ☐ Diabetes
- ☐ Hypothyroid/Hyperthyroid (circle one)
- ☐ Adrenal
- ☐ Osteoporosis/Osteopenia (circle one)
- ☐ Menopause

Lungs
- ☐ Asthma
- ☐ Emphysema/Chronic Bronchitis
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Pneumonia
- ☐ Collapsed Lung

Other:

Cancer (Please list type(s) and date(s):

1.

2.

3.

History of Radiation? ☐ YES (area:) ☐ NO

Please turn form over to complete.

Rheumatology
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia/Polymyalgia
- ☐ Ankylosing Spondylitis
- ☐ Scleroderma
- ☐ Chronic Fatigue
- ☐ Other:

Muscles/Bones
- ☐ Spinal Disc Injury
- ☐ Muscle Aches
- ☐ Joint Swelling
- ☐ Joint Pain
- ☐ Fractures (please list site(s) and date(s):
  1.
  2.
  3.
- ☐ Tendon Injuries/Sprains (list site(s) and date(s):
  1.
  2.
  3.

Skin
- ☐ Skin Ulcer
- ☐ Cellulitis
- ☐ Psoriasis
- ☐ Other:

Eyes
- ☐ Eyeglasses/contacts
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other:

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Other:

Neurological
- ☐ Seizures
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Lyme Disease
- ☐ Stroke
- ☐ Guillain-Barre
- ☐ Traumatic Brain Injury
- ☐ Memory Loss
- ☐ Concussion
- ☐ Dizziness
- ☐ Vertigo
- ☐ Headaches/Migraines
- ☐ Carpal Tunnel
- ☐ Cubital Tunnel
- ☐ Peripheral Nerve Injury
- ☐ Other:

Reproductive

Women
- ☐ Current pregnancy
  - ☐ Trying
- ☐ Number of past pregnancies:
- ☐ Deliveries (number)
  - ☐ Vaginal:
  - ☐ Cesarean:
- ☐ Oral Contraceptive
- ☐ Hormone Therapy
- ☐ Endometriosis
- ☐ Pelvic Pain

Men
- ☐ Prostate enlargement
- ☐ Hormone Therapy
- ☐ Other:

Ear/Nose/Throat
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Hearing Loss
- ☐ Difficulty swallowing
- ☐ Seasonal Allergies
- ☐ Vertigo
- ☐ Vocal Fold Paralysis
- ☐ Vocal Fold Nodules

Sleep

Average hours per night:
- ☐ Insomnia
- ☐ Restless Leg Syndrome
- ☐ Night Pain

Have you experienced any of the following? If yes, please list dates and injuries.

Motor vehicle accidents ☐ YES ☐ NO	Falls in the last year ☐ YES ☐ NO	Other traumas ☐YES ☐ NO

Have you recently noticed any of the following? (check all that apply):

- ☐ Nausea/Vomiting
- ☐ Unexplained weight loss/gain
- ☐ Excessive fatigue
- ☐ Numbness/Tingling
- ☐ Night pain
- ☐ Fever/chills/sweats
- ☐ Dizziness/Lightheadness
- ☐ Generalized weakness

Medications

Please list any prescription medications you are currently taking (include pills, injections & patches):

1. 5.
2. 6.
3. 7.
4. 8.

Please list any over the counter medications you are currently taking (include vitamins & supplements):

1. 5.
2. 6.
3. 7.
4. 8.

Surgical History

Please list any surgeries & dates:

1. 4.
2. 5.
3. 6.

Allergies

Are you latex sensitive? □ YES □ NO

List any medication allergies/reactions:

1. 4.
2. 5.
3. 6.

List any other food and/or other allergies you have:

1. 4.
2. 5.
3. 6.

Please indicate any other medical professionals from which you are receiving care:

□ Medical Doctor (MD/DO)	□ Occupational Therapist	□ Chiropractor
□ Cardiologist	□ Physical Therapist	□ Acupuncturist
□ Neurologist	□ Speech Therapist	□ Psychiatrist/Psychologist
□ Orthopedic	□ Massage Therapist	□ Dentist

Because domestic violence is so common, we routinely ask about it.
Have you ever been or are you currently being physically or emotionally abused? ▢ YES ▢ NO

Therapist Comments:

To the best of my knowledge and belief, the information I have given is complete and true.
I hereby give my consent to receive therapy services at Northern Dutchess Hospital.

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Name:	**DOB:**
What problem are you hoping to address with therapy?	
What are your goals for therapy?	
When did your problem begin?	What happened/caused problem?
Describe your initial symptoms:	
Diagnostic tests you may have had for this condition: ☐ MRI ☐ CT ☐ X-Ray ☐ EMG ☐ Blood work	
Where & approx. when were they performed?	Results of tests:
What makes your symptoms or pain worse?	What makes your pain or symptoms better?
Since this condition began, you symptoms have: ☐ Decreased ☐ Increased ☐ Not changed	
What activities are you **not** able to do now that are important to you?	
Have you ever had this problem before? ☐ YES ☐ NO If so, did it get better? ☐ YES ☐ NO How long did it last?	

At its best/least, your pain is (circle)**:**

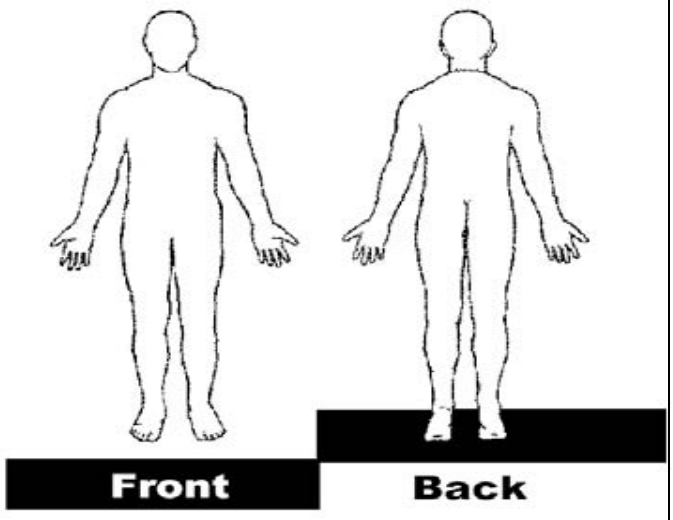
No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

At its worst, your pain is (circle)**:**

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10



Mark area(s) where you have pain above

Please describe the nature of your pain (check all that apply):

☐ Sharp	☐ Electrical	☐ Tingling	☐ Throbbing
☐ Dull	☐ Shooting	☐ Numbness	☐ Burning

Please turn form over to complete.

Is your pain:

□ Constant (never stops) □ Intermittent (comes and goes) □ Infrequent (activity dependent)

Are your symptoms worse in the: □ Morning □ Afternoon □ Night

Lifestyle

- How would you rate your energy level? Good/Fair/Poor
- What is your general stress level? Low/Medium/High
- Do you exercise outside of your normal activities?
  □ YES (days/week) □ NO
- Hobbies/leisure:

Nutritional Screening

- Have you ever had an eating disorder?
  □ YES ( )
  □ NO
- Have you experienced a recent loss of appetite? □ YES □ NO

- Do you smoke? □ YES □ NO

Recreational drug use? □ YES □ NO

- Number of caffeinated beverages per day?

Number of alcoholic beverages per day?

Please mark any of the following with which you are currently having difficulty (check all that apply):

□ Walking on:

□ Level ground □ Uneven ground
□ Stairs □ Ramps/incline

□ Sitting □ Standing □ Squatting

□ Self-care (dressing, bathing, eating, etc.)

□ Home management (household chores, shopping, etc.)

□ Transfers (moving from bed to chair, bed to toilet, etc.)

□ Community and work activities:

□ Bed mobility (getting in/out of bed, changing position)

□ Work/volunteering □ School □ Recreation □ Driving

Is there anything else you would like to tell me?

Therapist Comments:

To the best of my knowledge and belief, the information I have given is complete and true.
I hereby give my consent to receive therapy services at Northern Dutchess Hospital.

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____